Pop Warner Little Scholars, Inc.

2009 PHYSICAL FITNESS & MEDICAL HISTORY FORM

Special Note: This form must be dated after January 1, 2009 and then submitted to your LOCAL Pop Warner organization. No other forms are acceptable unless Section II is modified or substituted ONLY to comply with local and/or state laws or because of medical practitioner regulations (i.e. the medical practice insists on its own form). In either case, Section I must still be filled out entirely and attached to the modified/substituted form. Section II must be completed in its entirety ONLY by a Licensed State Examiner (medical doctor, , nurse practitioner, etc.)

Section I: FOR PARENT/GUARDIAN COMPLETION ONLY

Legal Name of Participant (must match birth certificate):

Last _____First_____Middle_____
Address:_____
City:_____State: _____Zip:_____
Telephone No:_____
Date of Birth: _____ Male__ Female __
Name of Primary Medical Insurance Company:_____
Policy Number: _____Membership Number:_____
Name of Primary Insured: _____
Sport (check one): Cheer__ Dance__ Tackle__ Flag__

PARTICIPANT MEDICAL HISTORY

1.	Are there any injuries requiring medical attention?	Yes	No
2.	Are there any past surgeries or scheduled surgeries?	Yes	No
3.	Is the participant currently under the care of a medical practitioner?	Yes	No
4.	Is the participant currently taking any medications?	Yes	No
5.	Does the participant have any allergies (penicillin, bee stings, etc)?	Yes	No
6.	Does the participant have asthma/require the use of an inhaler?	Yes	No
7.	Is the participant diabetic/require medication for diabetes?	Yes	No
8.	Does the participant currently require medication?	Yes	No
9.	Does/has the participant have/had seizures?	Yes	No
10.	Does the participant wear glasses or contact lenses?	Yes	No
11.	Does the participant wear a brace or other medical support device?	Yes	No
12.	Does the participant have any other physical limitations or medical conditions?	Yes	No

If you answered yes to any of the above questions, please provide the question number and an explanation in the following space:

_____
_____
_____
_____

I hereby certify that this information is accurate to the best of my knowledge. I understand that this medical authorization may be voided in the event of injury, illness or accident and my child may not be cleared for participation at such time. Furthermore, I hereby acknowledge that it is my responsibility to inform my child's coach or organization official in writing if there is any change in the medical condition of my child. I also understand that it's my responsibility to obtain written permission from my child's physician on official medical stationary in order to seek permission for my child to resume participation after any and all such injury, illness or accident.

Signature of Parent or Legal Guardian: _____

Print Name_____

Relationship to Participant_____

Dated_____

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Section II: THIS SECTION IS TO BE COMPLETED ONLY BY A MEDICAL PROFESSIONAL

Name of Participant:_____
(Please check the following if healthy or note otherwise):

Height	Weight	Eyes
Ears	Mouth	Nose & Throat
Respiratory	Cardiovascular	Neurological
Muskoskeletal	Dermatological	Blood Pressure

I hereby certify that I am a licensed state examiner and have examined the above named individual and understand that he/she will be involved in participating in Pop Warner football, cheer or dance programs. I hereby swear and attest that this individual is physically fit and I have found no medical reason which would prevent this individual from safely participating in Pop Warner activities for the 2009 season. I am therefore clearing this individual for athletic participation without limitation.

Please place medical professional stamp here or fill out the following:

Signed_____ Date:_____

Print Name_____

Please indicate medical profession (M.D., D.O. R.N., etc.)_____

Complete this section or the medical professional's stamp may be placed below.

Address_____City_____State_____

Telephone _____ /Fax Number: _____

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